City of Burlington
Flex Enrollment Form

For the Plan Year: January 1, 2020 to December 31, 2020

Name: _____ Social Security Number: _____

Street Address: _____

City, State and Zip: _____

I authorize my employer to make the following salary reductions:

❑ Health Care Flexible Spending Account (FSA)

(DO NOT ELECT IF YOU PARTICIPATE IN A QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN & HSA THROUGH YOUR SPOUSE'S EMPLOYER)

I elect to have $_____ annually ($_____ per pay-period) reduced from my salary before taxes to reimburse me for eligible health care expenses that I incur during the plan year specified above. If you are eligible for this plan, the maximum reimbursement is $2,550 per year.

❑ Dependent Care FSA

I elect to have $_____ annually ($_____ per pay-period) reduced from my salary before taxes to reimburse me for eligible daycare expenses that I incur during the plan year specified above. Reimbursement from this and other dependent care plans for which I may be eligible is limited to $5,000 per year (or $2,500 per year if I am married filing separately). Reimbursement is further limited to my earned income or my spouse's earned income, whichever is less.

I understand that:

- I cannot change my FSA elections during the plan year unless I have an eligible election change event.
- I may carry over up to $500 of my Health FSA election to the next plan year, any amounts exceeding $500 in my Health Care FSA account at the end of the year will be forfeited.
- Any amounts remaining in my Dependent Care FSA at the end of the year will be forfeited.
- My Social Security benefits may be reduced by this election.
- This election replaces any previous elections and will terminate on the earlier of: (1) the end of the plan year, (2) when I am no longer a qualified employee eligible to participate in the plan, (3) Plan termination.
- My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.
- If I am enrolling in the Traditional Health Care FSA, I am not eligible and therefore can't participate in an HSA, either individually or through my or my spouse's employer.

Signature_____Date_____

Return to Human Resources

Employer Use Only

Accepted by: _____ Effective Date: _____

Effective Date Information: For employees enrolling during open enrollment FSA Health and Dependent Care accounts will be effective on January 1st of 2020.

For employees enrolling at the time of hire the effective date will be the same as the employee's date of hire.